

## CRITERIA FOR PRIOR AUTHORIZATION

Multiple Sclerosis Interferons

**PROVIDER GROUP:** Pharmacy and Professional

**MANUAL GUIDELINES:** The following drug(s) require prior authorization:

- Avonex® (interferon beta-1a)
- Betaseron® (interferon beta-1b)
- Extavia® (interferon beta-1b)
- Plegridy® (interferon beta-1a)
- Rebif® (interferon beta-1a)

**CRITERIA:** (must meet all of the following)

- Patient must have a diagnosis of multiple sclerosis
- Age >/= 18.
- Absence of concurrent therapy with another disease-modifying MS agent: a different interferon, glatiramer, natalizumab, or fingolimod.
- Does not exceed the following quantity limits:
  - Betaseron (interferon beta-1b) – Quantity limit: 1 kit (of 14 units) per 28 days
  - Rebif (interferon beta-1a) – Quantity limit: 1 kit (of 12 units) per 28 days
  - Avonex (interferon beta-1a) – Quantity limit: 1 kit (of 4 vials/syringes/pens) per 28 days
  - Extavia (interferon beta-1b) – Quantity limit: 1 kit (15 units) per 30 days
  - Plegridy (interferon beta-1a) – Quantity limit: 1 kit (of 2 pens/syringes) per 28 days

**Prior authorizations will be approved for 1 year.**